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ABSTRACT

John Bowlby's theory of attachment is examined in the cultural and historical context in which it was developed. Bowlby trained as a psychiatrist in England during the 1920's and published the WHO report in 1951. Thus the origins of his theory can be related to events set in motion by the First World War and occurring during the interwar period and the Second World War. Bereavement was a widespread problem during and after the war, often precipitating cases of shell shock and civilian illness. Treatment of these problems led to widespread recognition in British psychiatry of the importance of neurotic as well as psychotic illness, of the role of environmental events in etiology, and of the importance of considering patients' relationship to other people as well as their individual psychology. It was recognized that infantile sexual trauma was not a necessary prerequisite to neurosis and infantile interaction with the mother was identified as another possible source of trauma. Another theory demoted the importance of sexual instinct and postulated an innate need for companionship whose frustration led to anger or depression. The culmination of these changes set the stage for Bowlby's work, which began in the late fifties and involved a conscious use of adult mourning as a paradigm for childhood separation anxiety. Implications relating to the generalizability of Bowlby's theory are discussed. (JMB)

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Britain Between the Wars: The
Historical Context of Bowlby's
Theory of Attachment

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Abstract

This paper concerns the cultural and historical context within which John Bowlby developed his theory of attachment. Bowlby trained as a psychiatrist in England during the 1920's and published the WHO report in 1951. Thus we look for the early origins of Bowlby's theory to events set in train by the First World War and occurring during the interwar period and the Second World War. The "Great War" produced several important changes in the practice of psychiatry in Britain, as well as more specifically in Freudian thought. Experience in treating cases of "shell shock" led to a decrease in organicist thought and an increased recognition of the existence of neurotic as well as psychotic disorders. The idea that infantile sexual trauma is a necessary component of neurosis was abandoned and there was increased recognition of the role of "object relations" since in many shell shock cases a precipitating factor was bereavement. Bereavement among civilians was also widespread (about 3/4 of a million men were killed in the war) and seems to have been a common problem among the caseloads of postwar therapists. We do not argue that Bowlby's theory of attachment is specific to the context in which it was developed. Bowlby may have overemphasized or distorted the role of separation and loss in psychic functioning, but whether or not this is the case is an empirical issue.

Britain Between the Wars. The Historical
Context of Bowlby's Theory of Attachment

As developmental psychology "comes of age," there is increasing interest in tracing the history of thought and research concerning children (Lomax, Kagan and Rosenkrantz, 1978; Sears, 1975; Senn, 1975). Such an enterprise offers the possibility of providing, not only a descriptive chronicle of personal or anecdotal interest, but a basis for insights into how our ideas have been shaped by the cultural context in which they were developed. It is, for instance, by now commonplace to note that much of Freud's thought needs to be seen in the context of nineteenth century Vienna, and that many of his perceptions may have been correct for the individuals he observed although they may fail as immutable observations of human behavior in general (e.g., Mitchell, 1974).

The present paper concerns the cultural and historical context of another major theorist of child development, John Bowlby. Bowlby's thought is currently the basis, of course, of a great deal of developmental research, and, for many, provides an attractive framework for considering affective processes throughout the life span, for instance, in delineating stages in the process of mourning a death (Parkes, 1972).

In looking for the historical context of Bowlby's thought, we should begin by reviewing some of the facts of his life (Bowlby, Note 1, Note 2). He was born in 1907, the second son of Sir Anthony Bowlby, a distinguished surgeon who was a major-general in the British army during World War I. Bowlby himself was a schoolboy during the war. He first became interested in psychology when introduced to the writings of Freud by his tutor at the Naval College at Dartmouth in 1924. This

interest continued during his years at Cambridge (1925-28). In 1927, after receiving a prize of £ 15, Bowlby purchased, among other books, W. H. R. Rivers' Instinct and the Unconscious. Rivers was a Cambridge anthropologist and psychologist who served as a doctor during the war in a hospital for shell-shock victims and whose experiences there led him to reformulate many of Freud's ideas. Following six months (1928-29) working at a school for emotionally maladjusted children, Bowlby attended University College Medical School (1929-33) and worked as a clinical assistant at the Maudsley Hospital (1933-36). During this period, he was also a student-candidate with the British Psychoanalytic Society and was analyzed by Joan Riviere, later much influenced by Melanie Klein. He began work at the London Child Guidance Clinic in 1936. His first work on the mother-infant bond appeared in the early 1940's (Bowlby, 1940). The major influences on his thought were the work of Klein (Bowlby, 1969, p.), an article by David Levy (1937) called "Primary affect hunger" and a book by Ian Suttie (1935), The origins of love and hate (Bowlby, Note 1).

These biographical facts suggest we should look for the early origins of Bowlby's theory to events set in train by the First World War, and occurring during the interwar period. The Second World War certainly had an influence on his thought which is very clear in the WHO report (Bowlby, 1951). Nevertheless, many of the important ideas in the later work clearly predated World War II, and are evident in work published by Klein and Suttie in the thirties. There is also a very clear influence of Suttie traceable in Bowlby's major work on attachment (1969). Thus, the focus of this paper is on the effect of the "Great War" on psychoanalytic thought and, more generally, on psychiatry in Britain.

Bowlby's own account of his work stresses its origins in his interest in achieving a prospective view of early pathogens. Freud had adopted a retrospective approach, beginning with the study of defense mechanisms and neurosis in adults, and working backwards to a description of the childhood roots of these disorders. Bowlby (1969, p.) saw himself as reversing this sequence, beginning with the study of separation anxiety in childhood and working forwards to adult neurosis. It was not until the late fifties, according to him, that he realized, while writing an introduction to Peter Marris' Widows and their families (1958), the commonalities between childhood separation anxiety and adult mourning (Bowlby, Note 1). Despite this disclaimer, the question remains: why was his attention directed to separation anxiety as an early pathogen? Was it affected by the widespread premature deaths of British men in the war, and the effects of bereavement on the British population in the twenties and thirties?

The war produced several changes crucial to the development of attachment theory: more widespread recognition of the existence of neurotic as well as psychotic disorders, revision of Freud's idea that infantile sexual trauma is a necessary component of neurosis, and, most importantly, increased recognition of the role of "object relations" in development. Experience in treating cases of "shell shock" both during and after the war was an important factor in producing these changes. Another important factor was the postwar atmosphere of bereavement, and the fact that caseloads apparently included substantial numbers of bereaved relatives of the approximately 3/4 of a million men killed in the war. Bereavement was not only numerically common in this period, but also likely to be psychologically problematic,

due to the dropout during the war of traditional funeral and mourning customs which exist in most societies to buffer grief (Rosenblatt, Walsh & Jackson, 1976). The decline of religion as a belief system which could help mourners by offering the comforts of immortality and the possibility of eventual reunion with the dead further increased the psychological problems of the bereaved.

The salience and problematic nature of mourning in British society between the wars combined with a bias existing in Freud as well as other thinkers, to look for the early roots of adult problems in childhood experience. It was natural to assume developmental continuity (see Kagan, Kearsley & Zelazo, 1978 for discussion of this assumption), natural when confronted with problems of pathological mourning and depression to look for similar problems in early childhood which produced sensitization to experiences of loss. Interest in such a search was enhanced by the recognition that Freud's theory of infantile sexual trauma as universally present in neurosis was not supported by wartime experience in treating shell shock.

Prewar Britain

Before the war, psychiatric treatment in Britain was basically available only to the psychotic, since admission to hospitals supported by public funds was possible only for the "certifiably insane" and private care was extremely expensive (Bower, 1899). Both theory and treatment were dominated by a medical materialism which held that the causes of all mental illness were physical. For example, Purves-Steward (1911) wrote in his text on nervous diseases, "Disease is inconceivable without some underlying physical basis. The lesion need not be visible microscopically: it may be molecular or biochemical."

(p. 355). Treatments were correspondingly physical in nature. A common treatment for the nervous patient, for instance, was the Weir-Mitchell procedure, in which patients were isolated, kept in bed for weeks, given massage, and overfed to build up "nerve energy" (Boyle, 1914).

There were a few exceptions to these rules. Savage (1891) wrote of the influence of surroundings on the production of insanity and argued that not all insanity was due to "direct neurotic heredity." He even mentioned grief as a possible cause, including observations such as: "The mother who has watched her dying child, and has anticipated its every cry, after its death fancies she still hears the cry of distress, and may in the end believe that her child is not dead." (p. 529). But a far more common view of the relationship between bereavement and mental illness was that of Maudsley (1895):

If his [the patient's] sadness be due to misfortune, bereavement, soured hope, disdained affection, crosses or losses in business, or other sufficient blow to self-interest or self-love, his dejected mind rallies, when in good health, and presently recovers its tone, his grief was natural grief proceeding from a natural motive and proportionate to its cause. But if his sadness is due to internal failure of the springs of reaction, without external cause as there may have been, then it is morbid. (p. 164)

Here Maudsley gave one description of the normal person and another of the melancholic. They were considered two different creatures, with no theoretical linkage between the two states of mind.

Freud had, of course, begun before the war to formulate much different theories of the origin of mental disease and to pay very serious attention to neurosis. But his work was not well-known in prewar Britain, and when known, was considered a foreign and sex-obsessed system. Furthermore, he emphasized the necessity of infantile

sexual trauma in the production of neurosis, ignoring elements of grief and anxiety over the severing of interpersonal bonds in, for instance, the case of Anna O. (Breuer & Freud, 1893).

Shell shock

"Shell shock" was the name given to a wide variety of neurotic disorders acquired by British soldiers during the First World War. Symptoms included insomnia, nightmares, hallucinations, irritability and difficulty carrying out duties (especially among officers, who tended to come from the middle and upper classes) and hysterical blindness, deafness, mutism and paralysis (especially common among working-class soldiers). At the beginning of the war, the symptoms were widely attributed to exposure to explosions (hence the name "shell shock") or else were considered evidence of cowardice or malingering and hence grounds for trial and possible execution. When treatment was provided, it was generally of the physical type:

Hysterical contractures were treated by means of elaborate and expensive instruments or my tenotomies [cutting of the tendon], hysterical vomiting in epidemic form was called gastritis and the patients were drugged with bismuth and fed by means of nutrient enemata, men who tilted their pelvis were given thick-soled boots for the apparent shortening of the lower limb and hysterical whisperers were recommended a dry bracing climate for their laryngities. (Culpin, 1924, p. 11)

As the war continued, however, views began to change. For one thing, cases of "shell shock" appeared in men never actually exposed to explosions or other battle trauma. Psychological factors began to be investigated as doctors observed their patients more closely, and grief for fallen comrades began to be identified as one possible cause of symptoms. For instance, Dr. William Aldren Turner (1915) noted that some patients appeared to be reliving their past experiences. A

patient of his, he reported, "would suddenly start and sit up in bed and look around him, crying out, 'He's gone, he's gone.' It was subsequently ascertained that this patient's brother had been killed when fighting beside him in the trench." (p. 345). Dr. Harold Wiltshire (1916) wrote specifically that, "Losses help to cause shell shock The effect does not depend upon single numbers, but upon clarity of realization, a few losses, or even a single loss, clearly seen, or including friends or relatives, being much more potent than large general losses." (p. 1211).

These insights were not, however, universally accepted, perhaps more importantly, there was no clear way to utilize them in treatment, since no theoretical understanding of the role of loss in personality functioning had been achieved. Psychoanalysis was tried in a few cases by doctors such as M. D. Eder, a charter member of the London Psychoanalytic Society who also used less extensive "talking cures" with other patients (Eder, 1917). A dilemma was soon discovered: prewar Freudian theory had linked neurosis to unresolved mental conflict dating from childhood, to infantile sexual trauma. Doctors working with shell shock, like Eder, generally failed to discover such traumata, however. This led to two developments in different schools of British psychiatry: (1) to the development, among non-Freudian doctors such as W. H. R. Rivers, of explanations of shell shock (and, by extension, of neuroses in general) which used the Freudian concepts of unconscious motivation and repression, while rejecting the search for infantile sexual trauma; this movement ultimately developed, in the postwar, into organization of a school of British eclectics, such as Ian Suttie, centered around the Tavistock Clinic, and (2) to considerable debate among orthodox

Freudians about the origins of neurosis, which ultimately led, in the postwar period, to revisions of Freudian theory, most notably by Melanie Klein, which made grief reactions more understandable.

Developments in "Eclectic" Psychiatry

W. H. R. Rivers was a physician and well-known Cambridge anthropologist before the war, who trained in psychological medicine in 1915 under a Freudian-oriented doctor, R. G. Rows, and then went to work in Craiglockhart, a military mental hospital which treated patients including Robert Graves and Siegfried Sassoon. In December 1917, Rivers delivered a paper to the Royal Society of Medicine in which he gave a down-to-earth account of how normal soldiers who had been through psychologically painful war experiences could become ill through attempting to banish their memories from consciousness. Rivers' experiences had led him to modify Freudian conceptions of dreams as wish fulfillment or repression. The distressing character of war dreams made the Freudian conception seem implausible, in what way was one fulfilling a wish when one dreamed of death and carnage? Rivers also redefined repression, which for Freud was an unconscious mechanism, as "an active or voluntary process by which it is attempted to remove some part of the mental content out of the field of attention" He thought that such attempts at repression, often urged on patients by well-meaning doctors and friends, were in fact detrimental, that such repression caused the exhausting and frightening dreams to which patients were subject:

[i]f a person voluntarily represses unpleasant thoughts during the day it is natural that they should rise into activity when the control of the waking state is removed by sleep It seems as if the thoughts repressed by day assume a painful quality when they come to the surface at night, far more intense than is ever attained during the day. (pp. 173, 176)

Rivers' ideas led him to attempt therapy which encouraged soldiers to abandon efforts at repression, to remember their war experiences but learn to reinterpret them and reassociate them in a way that would lessen their painful quality. He illustrated this recommendation with the case history of an officer who collapsed after finding a fellow officer and friend blown to pieces. The patient had been advised to try to forget the experience, but the very attempt led to worsening symptoms and dreams. Rivers "reinterpreted" the patient's experience by suggesting that:

... the mangled state of the body of his friend was conclusive evidence that he had been killed outright and had been spared the long and lingering illness and suffering which is too often the fate of those who sustain mortal wounds. He brightened at once He said he would no longer attempt to banish thoughts and memories of his friend from his mind, but would think of the pain and suffering he had been spared.

For several nights he had no dreams at all, and then came a night in which he dreamt that he went out into No Man's Land to seek his friend and saw his mangled body just as in other dreams, but without the horror which had always previously been present. He knelt beside his friend to save for the relatives any objects of value which were upon the body, a pious duty he had fulfilled in the actual scene, and as he was taking off the Sam Browne belt he woke with none of the horror and terror of the past, but weeping gently, feeling only grief for a friend.

In subsequent dreams the patient and his friend chatted together and the patient was able to tell his dead friend about his illness. There were occasional distressing dreams during this period, but the patient eventually recovered.

Rivers was surprised that his treatment led in this case to the appearance of a normal grief reaction, hitherto suppressed. The grief reaction was evidence, although Rivers did not note it explicitly at the time that the severing of adult relationships might cause distress and neurotic

symptoms even in the absence of childhood sexual trauma. Rivers (1923) suggested that psychoanalysis might best be considered a theory based on observations of civilians before the war, rather than a general theory of mental life in all people under all circumstances.

A further modification in Freudian theory suggested by Rivers (1923) was that:

... [the] instinct for self-preservation must be put side by side with the sexual instinct as the starting-point for the development of psycho-neurosis, and it is probable that, when attention is directed to it, the instinct of self-preservation will be found to play a far more important role in the production of the neuroses of civil life than most psycho-analysts are yet ready to recognize. (p. 151)

This suggestion was appealing to many British doctors, who had never been comfortable with Freud's emphasis of sexuality. Hugh Crichton Miller, the founder of the Tavistock Clinic, and J. A. Hadfield, who worked at the Tavistock, were among these doctors, and they exemplified also a second characteristic of those doctors who were coming to identify themselves as eclectics. a commitment to the Christian religion. Crichton Miller, for instance, was the son of a Presbyterian minister and an elder of St. Columba's in London, and Hadfield once treated a bereaved father by urging him "to renew his strength by resting his soul in the Everlasting Arms." The Tavistock Clinic itself was sometimes called the "parsons' clinic" because many staff members were deeply religious. These doctors objected to Freud as being insufficiently "hopeful," as well as, one may presume, finding him culturally alien as an atheist of Jewish origin.

All of these attitudes were abundantly evident in the work of Ian Suttie, who did the most of any of the eclectics to forge theoretical alternatives to Freudianism. Suttie, born in 1889, received medical

degrees from Glasgow in 1914 and then served in the First World War in France, India and Mesopotamia. On his return to England, he worked in several hospitals in Glasgow before joining the staff of the Tavistock Clinic. His major work, The Origins of Love and Hate, with an introduction by J. A. Hadfield, appeared in 1935, which was also the year of his untimely death. The book described a line of thought which had begun during the war ("twenty years ago," p. 3) and accelerated with the appearance of Freud's work on life and death instincts which "I had been compelled to reject ... from the time of its appearance." (p. 3). Suttie emphasized love and the need for companionship as an autonomous force in development, at least equal in importance to the sexual instinct, and probably innately present in infants due to its evolutionary adaptiveness. The need for love was considered the basis for human anxiety and "liability to psychogenic mental disorder" (p. 21) as well as the developmental origin of anger, hatred and aggression. He defined the neurotic, in almost casual parentheses (p. 58) as "(the sufferer from separation anxiety)" and argued that separation anxiety or loss gives rise in certain circumstances to hate, in others to grief, and in still others to a "flight into illness." "Mental or nervous breakdown is merely the culmination of social strains which have existed since early childhood" (p. 183).

Suttie's theory was a clear statement of an independent British depth psychology which avoided the physicalist views prevalent in Britain before the war while rejecting the pansexualism of Freud and his postulation of a death instinct. The emphasis on an innate and biologically-adaptive need for companionship which, when thwarted, gave rise to separation anxiety and to a variety of consequent

difficulties, was a statement of postulates later developed by Bowlby (1969) in his biological and ethological conception of attachment.

Developments in Freudian Psychiatry

Freud had begun to think about grief before the war, when he discussed some of the ideas of his essay "Mourning and Melancholia" with Ernest Jones in January 1914. The essay was written in 1915 and published in German in 1917. It began by describing in detail the process following a death or other loss, in which mental energy is first attached with great intensity to the lost object, and only gradually withdrawn, with great pain, at the demands of the ego that mental life should be in accord with reality, that is, that the fact of death must be recognized. Freud described the process of giving up the attachment as involving separate renunciations of all the different aspects of the life once shared with the dead person: each place visited together, each activity once shared was capable of evoking fresh feelings of loss.

The purpose of the essay was, however, less to describe mourning than to describe melancholia or depression, which was done by comparing and contrasting it with normal mourning. The states were similar in that each involved "profoundly painful dejection, cessation of interest in the outside world, loss of the capacity to love, [and] inhibition of all activity" The loss that led to mourning was a conscious loss, generally of a loved person. By contrast, the loss that led to melancholia was at least partially unconscious, that is, one was not aware or only partially aware of what one was missing. Freud said that "although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition,

and to refer it to medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful." In persons in whom mourning did not come to its expected end after time, Freud wrote that one suspected a "pathological disposition." Thus, despite the sensitivity of Freud's description of mourning, Freud was like Maudsley in assuming that it was a normal process not in need of medical aid, and not likely to lead to neurosis in people of basically sound mind. He admitted that he did not understand the mechanisms of mourning, writing in "On Transience" that "to psychologists mourning is a great riddle, one of those phenomena which cannot themselves be explained but to which other obscurities can be traced back."

As the war progressed and following its end, Freud became deeply concerned with the challenge of adjusting psychoanalytic theory to account for observations of war neurosis. The challenge shell shock presented to Freudian doctrine was that sexuality, and particularly infantile sexual trauma, was not found by most observers, British as well as foreign, as the predisposing factor in illness, as well as the fact that battle dreams were difficult to explain as wish fulfillment. Jones admitted in a speech to the Royal Society of Medicine in 1918 that:

The "presence or absence [of infantile sexual trauma] is a matter of greater theoretical importance than might perhaps appear, even though its practical importance may often not be great," (i.e., shell-shock patients could be cured by other than strictly psychoanalytic techniques). (p. 32)

Bernard Hart, another British Freudian, outlined the most popular explanation of shell shock when he wrote of it as an unconscious conflict in which an instinct for self-preservation clashed with the

conscious sense of duty to be a brave soldier. Neurosis, or "the flight into illness," was the unconscious solution to the dilemma. The soldier achieved his unconscious aim of self-preservation without the cost of seeing himself as a cowardly malingerer. This exploration was not in line with orthodox Freudian theory, but not all Freudians were disturbed by this. Culpin (1924) wrote that:

I do not regard as important the question whether all the minor psychoses [i.e., neuroses] have a sexual basis: sexual trauma as a universal basis was never a tenet of psycho-analysis (p. 18)

But Freud himself was not satisfied with such glosses on the problem and set to work to make fundamental changes in his thought to deal with the difficulties. In Beyond the Pleasure Principle (1920), he discussed the phenomenon of recurrent battle dreams and tried to reconcile these with his idea that dreams were wish fulfillments. He explained the recurrent dreams as due to what he termed "repetition compulsion," the attempt to master difficult experiences by repeating them. Freud argued that repetition compulsion was a general principle of the mind, and he connected it to the "death instinct," which he defined as the desire of living organisms to return to the inorganic state from which they arose. Freud ~~reconciled~~ composed this biologically ill-conceived notion with a life instinct ~~that~~ fought against it. Aside from being hard to follow, these ideas, as John Rickman (1927), an orthodox Freudian and former shell-shock doctor acknowledged, were of no clinical value. Freud's attempt to explain the observations of war neuroses in terms of the biological models which underlay his prewar sexual theory of the neuroses was judged by most a failure (Jones, 1957, p. 266).

Freud's prewar idea of infantile trauma as a necessary predisposing factor in adult neuroses was taken up with reference to mourning by Melanie Klein. Klein was a German analyst who came to live in London in 1926 at the invitation of Jones, and quickly made a favorable impression on many British Freudians (e.g., Rickman, 1927, Stephen, 1933). She did for pathological mourning what Freud had done for other neurotic illnesses. That is, she presented a theory connecting pathological grief in adult life to childhood trauma and not simply to the way a person with a "pathological disposition" reacted to the death of loved ones. Freud himself, it will be recalled from the discussion of "Mourning and Melancholia," had not been able to explain this riddle. Klein's theory was a vital link leading to the widespread recognition by psychiatrists that grief could lead to neurosis in people who had not hitherto shown problems, and to the recognition that mourning was, for all people, a difficult and dangerous period.

Klein argued that a normal child's experiences of separating himself from his mother, beginning with weaning from the breast or bottle, have parallels with the separation experience on adult undergoes in losing a loved person. The similar psychological process involved in the experiences of adult mourning and infant separation from the mother was a painful bit-by-bit withdrawal of mental energy from the lost "object" (i.e., person). The goal of this process of "reality testing" was to arrive at a state in which the mental image of the lost object was incorporated within the baby's or mourner's mind. The way the child responds to the early separation experiences was said to condition the way he would handle adult losses, i.e., either normally or pathologically. Klein (1940) wrote that "the person

who fails in the work of mourning ... [has] been unable in early childhood ... to feel secure in [his] inner world.' (p. 153).

Thus, by the 1930's, both these major strains in British psychiatry, the eclectic and the psychoanalytic, were stressing the importance of "object relations," that is, relationships with other people. The practical importance of this move away from individual psychology may be seen in an article by Rickman (1941) comparing the treatment of war neurosis in the two world wars. Rickman treated a soldier in the Second World War whose arm remained paralyzed after his wound had healed. The soldier received the wound at the same time his comrade was killed. Rickman suggested to the soldier that his arm represented his dead companion, whose death he could not accept. Although the soldier rejected the tendered explanation, he soon started a normal grieving process for his friend, at the end of which his arm recovered function. Wilson (1941) also described the depressive states which became more common in World War Two as pathological mourning-reactions, based on injuries to loved ones, or on injuries to self-love. (Wilson was a Tavistock doctor temporarily commissioned in the Royal Army Medical Corps.)

Bereavement in the post-war period

Two lines of development in British psychiatry after the war have been traced, with attention to the stimulus provided by observations of war neurosis, which in many cases involved mourning for lost comrades and relatives. But bereavement was also widespread among the general British population. Roughly 3/4 of a million British men died in the First World War, out of a total population of 38 million, and these deaths were concentrated in a single age cohort of young men (Taylor,

1970). About a third of the dead were married, these men left 248,000 widows and 381,000 children (Dearle, 1940). The others left parents, grandparents and siblings. One historian of the interwar years has written that, "the sense of loss and waste was still strong. Hardly a family but had lost one or more of its sons, often in the first promise of youth. Widows struggling to bring up fatherless children, women in their twenties, their sweethearts killed, facing long years of spinsterhood There was restlessness and unease about the future." (Howat, 1961, p. 203).

Bereavement was not only a widespread problem in the twenties, the war had made it a more problematic state, more difficult to cope with than before the war. Funeral and mourning customs were sharply curtailed during the war and not extensively revived after it. This eliminated the cultural support for the psychological work of mourning which had been provided by customs, which used to prescribe what one should do to honor the dead and for how long, "marking" the mourner as someone in a special state of mind to those with whom s/he came in contact. Such customs are cross-culturally nearly universal, and do seem to aid the mourner in successful resolution of feelings (Rosenblatt, Walsh and Jackson, 1976). The war also accelerated the decline of religion, thus depriving mourners of the comforts of belief in immortality, divine purpose to death and eventual reunion with loved ones, as well as the more concrete help of sympathy from clergymen and solace from prayer. A third cultural trend making mourning problematic in the twenties was that the dominant mood of the war had been a stoical patriotism which advocated suppression of grief in order to keep up morale and allow people to channel energy into the war effort, and

after the war, the dominant mood was a revulsion at the war and a desire to forget it all and emphasize the gayer aspects of life. Both attitudes involved repression of emotion, exactly what Freud had suggested in 'Mourning and Melancholia' as likely to lead to pathological mourning and depression. (For a much fuller account of these trends than is possible here, see Lerner, 1975, 1979.)

How many cases of pathological mourning or grief-related neurosis or psychosis were actually seen by psychiatrists and psychologists in the interwar years? Unfortunately, no exact figures on caseloads are available, but literary evidence, journal articles and case notes all suggest that such cases were common. One of the cases presented by Somerville (1923) in an article on the continuation of war neurosis in peacetime was one of the former soldier afflicted by fits. These were precipitated by hallucinations of a scene in which he had witnessed his closest friend 'blown to pieces.' The episodes occurred during 'larks' with his present friends which reminded him of former ones with his dead friend.

Mapother and Martin (1922) described a civilian case, involving a domestic servant, 'Mary,' admitted to the hospital in 1920. According to Mary's sister she had been 'prostrated for a time, and then confused and depressed' following the death of her older brother in the war in 1916. Following his death, Mary left domestic service for the munitions factory. After the war Mary suffered under the delusion that she had had regular intercourse with her brother for several years prior to his death. While under the care of Edward Mapother, who was soon to become superintendent of the Maudsley Hospital, Mary died of tubercular peritonitis. The disease had caused abdominal swelling, which, according

to Mapother, had suggested to Mary the idea that she was pregnant by her brother.

While Mary's case was a severe one, there were many minor neurotic manifestations of bereavement. Davies-Jones (1922) described the inadvertent discovery of such a case in one of his friends, who forgot for two hours how to knot his tie. In telling Davies-Jones about this event the friend said that after it happened he went to "dinner--I mean breakfast." Curious about the slip of the tongue, Davies-Jones asked him if he had any dreams. "I never dream, when I go to bed I die till the morning," he replied, but then added, "Of course I sleep, I don't die." Asked to "associate upon death," he recalled the death of his soldier brother. News of the brother's death had come as the family was enjoying an after-dinner toast to the fact that all the brothers had survived the war. This brother's "kit" had arrived home in dribblets, "keeping the wound open." The collars which the doctor's friend wore with his tie had come from this kit.

Brittain (1933) described a similar, if more severe, neurotic manifestation of bereavement which appeared in her postwar years at Oxford. She had lost her fiance, her brother, and two close male friends in the war, and at Oxford felt herself fighting nervous collapse and developing an obsessional grief that she was growing a beard. (This is especially interesting since identification with the dead is common during mourning.)

Robert Graves, whose wartime neurasthenia was clearly bound up with grief, maintained contact with therapists he had met during the war, including Rivers, although he apparently did not continue treatment as such. He instead pursued his own study of "the dream psychology in

which I was then interested as a means of curing myself.' (Graves, 1929, pp. 388-389).

Cases involving grief at deaths which were not related to the war of course occurred as well. But before the war the relationship of the problems to mourning would often not be noted, or would be minimized, as in Freud's case of Anna O. or a British case presented by Wilkinson (1914) in which Wilkinson argued that a father's death six months prior to the onset of anorexia nervosa was insufficient explanation of the illness, postulating instead a secret love affair of which there seems to have been no tangible evidence. By contrast, postwar discussions referred extensively and respectfully to bereavement. For instance, the Tavistock Report for 1920-27 gave the history of a 32-year old woman whose insomnia, lassitude and muscle cramps were related to her father's long illness, her refusal of a marriage proposal in order to nurse him, and his eventual death.

When Bowlby began to do therapy at the Maudsley in 1933-34, he did thorough psychosocial case histories and, as a consequence, became aware of bereavement as a factor in psychosis and registered an M.D. thesis which would have included a discussion of this link (Bowlby, Note 1). This thesis was never completed, but a work on classification of mental illness was accepted for the M.D. degree in 1939 and was published as Personality and mental illness (1942). Patients discussed in this book had been seen in 1933-34 at the Maudsley or University College Hospital. Bowlby linked the illnesses of many to losses (pp. 61, 82, 96, 146, 147, 153, 162, and described anniversary reactions (exacerbations of illness on the anniversary of a death). He commented on Freud's cases of women who had developed psychological

symptoms while nursing sick relatives that, "Now investigation has shown that the illness or death of a near relative is an exceedingly common precipitating factor in both psycho-neuroses and functional psychoses." Perhaps most interesting was the discussion of Case No. 29, who had seven schizoid traits on Bowlby's checklist, but whom he considered probably depressive rather than schizophrenic albeit possessed of a special, and puzzling, type of emotional unresponsivity. The mother had died when the patient was two and foster parents had raised the child. Bowlby proposed that sudden loss of a parent or sibling, or care in a succession of foster homes "may be disastrous for developing personality" (p. 194).

Conclusion

Bereavement was a widespread problem during and after the war, precipitating cases of shell shock and civilian illness. Treatment of these problems led to a widespread recognition in British psychiatry of the importance of neurotic as well as psychotic illness, in the role of environmental events in etiology, and of the importance of considering patients' relationship to other people as well as their individual psychology. The recognition that infantile sexual trauma was not a necessary prerequisite to neurosis led to perturbation among Freudians; one solution was Melanie Klein's identification of infantile interactions with mother as another possible source of trauma. Another solution was Suttie's demotion of the importance of sexual instinct and his postulation of an innate need-for-companionship, whose frustration led to anger or depression.

Bowlby's work, beginning in the late fifties, involved a conscious use of adult mourning as a paradigm for childhood separation anxiety.

One of the possibilities suggested in this paper is that attention was drawn to separation anxiety, in the twenties and thirties, by experience with adult mourning reactions, combined with a deep commitment to tracing the early roots of adult disorders and an assumption of a strong form of developmental continuity. The search for early roots was of particular interest because something was needed to replace infantile sexual trauma as the root cause of neurosis.

There are several possible interpretations of the historical argument presented here. One would suggest that Bowlby's theory of attachment is specific to the context in which it was developed, and therefore does not delineate laws of human behavior of any wide generality. Another interpretation begins with the idea that human behavior in response to separation and loss is an extremely salient issue in times of war although of importance whenever it occurs. Thus Bowlby's observations and those of the workers who preceded him were merely easier to make at a time of widespread separation and loss, but are equally valid for other contexts, including our present society. Distinguishing between these two positions is an empirical issue, not possible to evaluate with historical data. The virtue of the historical analysis is to point up the issues involved, alerting us to the issue of generality and the need for observations in a variety of cultural contexts, as well as the need to carefully consider the usefulness of attachment theory in cases of separation less extended and severe than that caused by death.

Reference Notes

1. Interviews with John Bowlby conducted by Jeffrey Lerner, London, June 28, 1976 and July 20, 1976.
2. Interview with John Bowlby conducted by Milton J. E. Senn, London, October 19, 1977. Transcript available from National Library of Medicine, Bethesda, Maryland.

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